STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC #2	Acceptable 445304	A. BUILDING _____ B. WING _____	07/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDRIDGE HEALTH AND REHAB CTR	456 WAYNE AVENUE CROSSVILLE, TN 38555

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F 000	INITIAL COMMENTS During the Recertification survey and investigation of complaint #41640, conducted from 7/17/17 through 7/19/17, at Wyndridge Health and Rehab Center, no deficiencies were cited in relation to the complaint under 42 CFR PART 483, Requirements for Long Term Care.	F 000	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid Requirements and Tennessee requirements when necessary. This corrective action plan is submitted as required under the regulations that governing participation in the Medicare/Medicaid programs. It should not be construed as an admission of any alleged findings or conclusions of the state survey agency.	
F 256 SS=D	483.10(i)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS (i)(5) Adequate and comfortable lighting levels in all areas; This REQUIREMENT is not met as evidenced by: Based on medical record review, interview and observation, the facility failed to ensure 1 resident (#187) had adequate lighting for reading, of 33 residents reviewed. The findings included: Medical record review revealed Resident #187 was admitted to the facility on 6/24/17. The nursing assessment dated 7/6/17 documented that Resident #187 did not wear glasses. Review of the admission nursing progress note dated 7/6/17, revealed Resident #187 was alert, oriented and had a "Brief Interview of Mental Status" (BIMS) of 13/15 indicating he was cognitively intact. Interview on 7/19/17 at 7:30 AM with Resident #187 revealed the lighting in his room is poor and he had difficulty reading his books and newspapers. Resident #187 stated that during the day he was able to open the window curtains so he had adequate lighting to read, but at night he	F 256	1. What corrective action(s) will be accomplished for those residents found to have been affected: On 7/19/17 Maintenance notified and resident #187 light bulb was changed. 2. How you will identify other residents having the Potential to be affected by the same deficient Practice and what corrective action will be taken. On 7/19/17 light bulbs were checked by maintenance Staff in all rooms. No other residents adversely Affected.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Bill Bacon — Administrator — 8-18-17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 256	Continued From page 1 did not have adequate lighting to read. Observation with the Maintenance Director (MD) on 7/19/17 at 7:36 AM, in the resident's room, revealed Resident #187's overhead bed light cover was off and the light bulb was burnt out. Interview with the MD on 7/19/16 at 7:36 AM in the resident's room, confirmed the overhead bed top light was out (burnt out). He stated he would replace the light bulb. The MD stated maintenance staff were supposed to check for burnt out bulbs in the resident's rooms when they had down time and the nursing staff were supposed to write a work order when repairs are needed. The MD checked the maintenance work order log book which was located at the nurse's station and there was no evidence found regarding a work order to have the overhead bed light replaced.	F 256	3. What measures will be put into place or what Systematic changes you will make to ensure that the Deficient practice does not occur: Director of Nursing and Assistant Director of Nursing will Educate On 8/4/17 all of nursing full time, part time, PRN, and Department Heads on discovery of light bulbs no longer working new staff will be educated in orientation. (Exhibit A)	8/7/17
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the	F 280	4. How the corrective action(s) will be monitored to Ensure the deficient practice will not recur,i.e.what quality assurance program will be put into place. Maintenance department checks Maintenance book each morning and Replaces bulbs as needed. Results will be reported to QAPI Committee including Administration, Director Of nursing, Assistant Director of Nursing, Medical Director, Pharmacist, Risk Manager, Unit Managers, Director of Respiratory services, Therapy Manager, Dietary Manager, Social Services, Maintenance Supervisor, Admissions, Environmental services and Activities.	

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F 280	Continued From page 2 plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 280	1. What corrective action(s) will be accomplished for those residents found to have been affected: Resident readmitted from Hospital with indwelling Catheter. Not indicated on Care plan and No physician order for Catheter . Resident #11Catheter was removed on 7/18/17 No other residents were affected. 2. How you will identify other residents having the Potential to be affected by the same deficient Practice and what corrective action will be taken: 7/18/17, DON, MDS staff verified care plans for residents with indwelling catheters. All other residents with indwelling catheters had current care plan. No other residents adversely affected. 3. What measures will be put into place or what Systematic changes you will make to ensure that the Deficient practice does not occur Director of Nursing and Assistant Director educate all Nursing, full time, part time, PRN, and Department Heads on 7/19/17 for Foley Catheter Care including MDS receiving orders For accurate care plans new staff will be educated during Orientation. (Exhibit B)	9/2/17

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F 280	Continued From page 3 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure 1 resident (#11) with an indwelling catheter, had a care plan revision to develop interventions for the care of a new indwelling catheter, of 3 residents reviewed for urinary incontinence, of 33 residents reviewed. The findings included: Review of "Physician's Orders" dated 7/14/17, revealed Resident #11 was re-admitted to the facility from the hospital with a newly placed indwelling catheter, on 7/14/17. Review of Resident #11's admission "Minimum	F 280	4. How the corrective action(s) will be monitored to Ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place DON, ADON, MDS Coordinator or MDS assistants will monitor care plans. daily for Accuracy. Results will be reported to QAPI Committee including Administration, Director Of nursing, Assistant Director of Nursing, Medical Director, Pharmacist, Risk Manager, Unit Managers, Director of Respiratory services, Therapy Manager, Dietary Manager Social Services, Maintenance Supervisor, Admissions Environmental services and Activities.	

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F 280	Continued From page 4 Data Set" (MDS) assessment, dated 3/27/17, indicated in "Section H0300- Urinary Continence," that the resident was frequently incontinent of urine. Continued review revealed no documentation of an indwelling catheter at the time of the assessment. Review of Resident #11's care plan for his documented problem with incontinence, including an onset dated of 3/14/17, indicated the resident was frequently incontinent of bladder. The interventions included: "Providing the resident with regular intervals of verbal cueing to toilet, assess him for abdominal distention (s/s [signs and symptoms] of retention)...assist [resident name] to bathroom or commode as needed at regular interval ... Check for incontinence at regular intervals, change promptly and assist with peri care as needed ...Use incontinence pads/briefs for [resident name] as needed. Change promptly when soiled ..." Continued review revealed the care plan had not been revised to include care and interventions for the catheter Resident #11 had in place when he was re-admitted from the hospital on 7/14/17. Interview with the Unit Manager, Licensed Practical Nurse (LPN) #1, on 7/18/17 at 9:20 A.M., confirmed Resident #11 had an indwelling catheter.	F 280		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and	F 323	1. What corrective action(s) will be accomplished for those residents found to have been affected: On 7/17/17 damaged smoking apron for resident #2 and resident #3were removed by nursing staff No other residents were affected.	

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F 323	Continued From page 5 (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of facility policy and interview, the facility failed to ensure smoking aprons were in good repair for 2 (#2 and #3) of 2 residents observed, and failed to ensure hot water temperatures were within the range of 105-115 degrees F (Fahrenheit) in 3 resident rooms. The findings included: Review of Resident #2's quarterly "Minimum Data Set" (MDS) assessment dated 4/21/17 revealed an admission date to the facility on 4/27/1982. Resident #2's diagnoses included hypertension, seizure disorder, and moderate intellectual disabilities. Resident #2's BIMS summary score was 7 out of 15 indicating cognitive impairment.	F 323	2. How you will identify other residents having. the Potential to be affected by the same deficient Practice and what corrective action will be taken: All residents of the facility who Smoke have the potential to be affected. All smoking aprons were inspected by nursing staff. All Damaged aprons removed. 7/17/17 3. What measures will be put into place or what Systematic changes you will make to ensure that the Deficient practice does not occur: New smoking aprons ordered 7/17/17. New Smoking aprons received on 7/21/17. All Nursing Staff Educated by DON, ADON On 7/19/17 for monitoring the aprons for damage. New staff will be educated in orientation (Exhibit C) 4. How the corrective action(s) will be monitored to Ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place. Nursing Staff who assist with smoke breaks Will monitor smoking aprons during each Smoke break for Damage. Staff will notify DON or ADON of damaged Aprons so new aprons can be ordered. Results will be reported to QAPI Committee including Administration, Director Of nursing , Assistant Director of Nursing, Medical Director, Pharmacist, Risk Manager, Unit Managers, Director of Respiratory services,Therapy Manager, Dietary Manager Social Services, Maintenance Supervisor, Admissions, Environmental services and Activities	9/2/17)

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F 323	Continued From page 6 Review of Resident #3's quarterly "Minimum Data Set" (MDS) assessment dated 6/4/17 revealed an admission date to the facility on 10/11/2013. Resident #3's diagnoses included aphasia, Cerebral Palsy, anxiety, depression, and intellectual disabilities. Resident #3's BIMS summary score was 0 out of 15 indicating severe cognitive impairment. Observation on 7/17/17 at 10:06 AM revealed Resident #2 was outside sitting in his wheelchair, smoking a cigarette. Continued observation revealed his smoking apron had a baseball sized hole. Observation on 7/18/18 at 10:23 AM revealed Resident #3 was outside sitting in her wheelchair, smoking a cigarette. Continued observation revealed her smoking apron had a baseball sized hole. Interview on 7/17/17 at 10:09 AM with Helper #1 confirmed holes were not supposed to be in the smoking aprons. Review of the facility's "Periodic Testing of Hot Water" policy undated revealed: "Testing of water temperature is to insure (sic) that the water is not too hot or too cold for a patient's comfort. Periodic testing of hot water is done weekly on all wings in different rooms each week. Also hot water in all central baths will be checked every week to insure (sic) they are in range of 105 to 115 degrees. If the water temperatures are not in the range of 105 to 115 there will be an adjustment done and a check made until the water temperature is back within the stated range."	F 323	1.What corrective action(s) will be accomplished for those residents found to have been affected: Water temps in room #104, room#202, And Room #303 were adjusted to proper Range of 105 degrees F – 115 degrees F On 7/18/17 No residents were affected. 2.How you will identify other residents having. the Potential to be affected by the same deficient Practice and what corrective action will be taken: On 7/18/17Maintenance staff checked all other resident rooms And water temps were in range of 105 degrees F – 115 degrees F. 3. What measures will be put into place or what Systematic changes you will make to ensure that the Deficient practice does not occur: Maintenance director educated all maintenance Staff 7/20/17 on water temps and testing. (Exhibit D)	9/2/17

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F 323	Continued From page 6 Review of Resident #3's quarterly "Minimum Data Set" (MDS) assessment dated 6/4/17 revealed an admission date to the facility on 10/11/2013. Resident #3's diagnoses included aphasia, Cerebral Palsy, anxiety, depression, and intellectual disabilities. Resident #3's BIMS summary score was 0 out of 15 indicating severe cognitive impairment. Observation on 7/17/17 at 10:06 AM revealed Resident #2 was outside sitting in his wheelchair, smoking a cigarette. Continued observation revealed his smoking apron had a baseball sized hole. Observation on 7/18/18 at 10:23 AM revealed Resident #3 was outside sitting in her wheelchair, smoking a cigarette. Continued observation revealed her smoking apron had a baseball sized hole. Interview on 7/17/17 at 10:09 AM with Helper #1 confirmed holes were not supposed to be in the smoking aprons. Review of the facility's "Periodic Testing of Hot Water" policy undated revealed: "Testing of water temperature is to insure (sic) that the water is not too hot or too cold for a patient's comfort. Periodic testing of hot water is done weekly on all wings in different rooms each week. Also hot water in all central baths will be checked every week to insure (sic) they are in range of 105 to 115 degrees. If the water temperatures are not in the range of 105 to 115 there will be an adjustment done and a check made until the water temperature is back within the stated range."	F 323	1.What corrective action(s) will be accomplished for those residents found to have been affected: Water temps in room #104, room#202, And Room #303 were adjusted to proper Range of 105 degrees F – 115 degrees F On 7/18/17 No residents were affected. 2.How you will identify other residents having. the Potential to be affected by the same deficient Practice and what corrective action will be taken: On 7/18/17Maintenance staff checked all other resident rooms And water temps were in range of 105 degrees F – 115 degrees F. 3. What measures will be put into place or what Systematic changes you will make to ensure that the Deficient practice does not occur; Maintenance director educated all maintenance Staff 7/20/17 on water temps and testing. (Exhibit D)	9/2/17

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F 323	Continued From page 7 Observations conducted with the Maintenance Worker (MW) on 7/18/17 between 4:06 PM to 4:49 PM revealed the resident's water temperatures from the sinks in their room/bathroom revealed, room #104, room #202 and room #302 were 117.7 degrees F. Interview on 7/18/17 at 4:22 PM with the MW confirmed the resident's water temperatures in their rooms were supposed to be between 105 degrees F and 115 degrees F.	F 323	4. How the corrective action(s) will be monitored to Ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place. Maintenance staff will monitor water temps on weekly basis in order to maintain water temps to 105 to 115 degrees F. Results will be reported to QAPI Committee including Administration, Director Of nursing, Assistant Director of Nursing, Medical Director, Pharmacist, Risk Manager, Unit Managers, Director of Respiratory services, Therapy Manager, Dietary Manager Social Services, Maintenance Supervisor, Admissions Environmental services and Activities.	
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.	F 371		

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F 371	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on review of facility policy, observation and interview, the facility failed to ensure honey thickened milk was at the correct temperature when served to residents. Findings include: Review of the undated "Dietary Policy/ Procedures Food Temperature" policy revealed "Food Temperature, Purpose: Foods will be maintained at proper temperature to insure (sic) food safety ...The temperature of potentially hazardous cold foods will be not greater than 40 degrees F (Fahrenheit) during tray assembly and 45 degrees F when served to the resident ..." Observation on 7/17/17 at 11:03 AM revealed there were four cups of honey thickened milk sitting on serving trays. The cups of milk were not sitting in ice baths nor had any other cooling mechanism. Continued observation revealed Dietary Aide (DA) #1 checked four 8 ounces cups of the honey thickened milk and the temperatures were 47 degrees F for one cup and the other three cups were 50 degrees F. Interview on 7/17/17 at 11:12 AM with DA#1 confirmed the temperature of the milk was supposed to be 40 degrees F or below. She stated that after the milk was opened it was supposed to be refrigerated. DA#1 stated she did not know how long the cups of milk had been sitting out on the serving tray. Observation on 7/17/17 at 11:13 AM of the walk-in refrigerator revealed that there was a 32 OZ milk container of Honey Consistency "Thick	F 371	1.What corrective action(s) will be accomplished for those residents found to have been affected: Honey Thick milk with elevated temperature was discarded 7/17/17by dietary aid. No residents were affected. 2. How you will identify other residents having the Potential to be affected by the same deficient Practice and what corrective action will be taken: On 7/17/17All other Honey Thick milk temps were checked By dietary aid and was within normal temperature range. 3. What measures will be put into place or what Systematic changes you will make to ensure that the Deficient practice does not occur: Dietary Manager and assistant Dietary manager Educated all Dietary staff 7/20/17 -7/21/17 on proper Thickened milk temps. (Exhibit E) Food temps will be monitored by dietary Staff before meal Times to confirm proper temps are maintained. Food Temps will be documented on temp log sheet. (Exhibit F)	9/2/17 9/2/17

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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F 371	Continued From page 9 and Easy." The instructions on the back of the milk container revealed the following: "Refrigerator prior to serving. Refrigerate after opening." In an interview on 7/18/17 at 3:42 PM the Dietitian confirmed that the milk temperatures should be 40 degrees F or below.	F 371	4. How the corrective action(s) will be monitored to Ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place. Dietary manager and assistant dietary manager will monitor Food temp log sheets on weekly basis Food temps log sheets will be reported to QAPI. Committee including Administration, Director Of nursing, Assistant Director of Nursing, Medical Director, Pharmacist, Risk Manager, Unit Managers, Director of Respiratory services, Therapy Manager, Dietary Manager Social Services, Maintenance Supervisor, Admissions Environmental services and Activities	